Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State of Iowa** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. **Program Title:**
Home and Community Based Services - Children's Mental Health (CMH) Waiver

C. **Waiver Number:IA.0819**

D. **Amendment Number:**

E. **Proposed Effective Date:** *(mm/dd/yy)*
05/01/16
Approved Effective Date of Waiver being Amended: 07/01/13

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
Effective May 4, 2016 the department intends to begin utilizing the InterRAI or other department approved standardized assessment tool for the purposes of level of care determination and service planning for the Children's Mental Health waivers. The InterRAI will be completed initially by the member's MCO and again during the annual level of care review.

The department is changing to the InterRAI standardized assessment tool as the current process of the integrated health home care coordinator completing the Targeted Case Management Comprehensive Functional Assessment is not a valid and standardized process for assessing level of care across a population.

The adoption of a standardized comprehensive functional assessment tool is specified in Iowa's application for enhanced federal Medicaid funding under the federal Balancing Incentive Payment Program (BIPP, established by Pub. L. No. 111-148, § 10202) which was submitted pursuant to the state legislature's direction in 2012 Iowa Acts, ch. 1133 (S.F. 2336), § 14.

3. Nature of the Amendment

A. **Component(s) of the Approved Waiver Affected by the Amendment.** This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☐ Waiver Application	
☐ Appendix A – Waiver Administration and Operation	
☑ Appendix B – Participant Access and Eligibility	
☐ Appendix C – Participant Services	
☑ Appendix D – Participant Centered Service Planning and Delivery	
☐ Appendix E – Participant Direction of Services	
☐ Appendix F – Participant Rights	
☐ Appendix G – Participant Safeguards	
☐ Appendix H	
☐ Appendix I – Financial Accountability	
☐ Appendix J – Cost-Neutrality Demonstration	

B. **Nature of the Amendment.** Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

☐ **Modify target group(s)**

- ☐ **Modify Medicaid eligibility**
- ☐ **Add/delete services**
- ☐ **Revise service specifications**
- ☐ **Revise provider qualifications**
- ☐ **Increase/decrease number of participants**
- ☐ **Revise cost neutrality demonstration**
- ☐ **Add participant-direction of services**
- ☑ **Other**

Specify:
The department intends to begin using the interRAI standardized assessment tool for the purposes of level of care determination and service planning for this waiver population

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State of Iowa** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. **Program Title** (*optional - this title will be used to locate this waiver in the finder*):
Home and Community Based Services - Children's Mental Health (CMH) Waiver

C. **Type of Request: amendment**

Requested Approval Period: *(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Draft ID: **IA.013.01.03**

D. **Type of Waiver** *(select only one):*
Regular Waiver

E. **Proposed Effective Date of Waiver being Amended: 07/01/13**
Approved Effective Date of Waiver being Amended: 07/01/13

1. Request Information (2 of 3)

F. **Level(s) of Care.** This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

☑ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**
If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

◉ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility as defined in 42 CFR □□440.40 and 42 CFR □□440.155**
If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☐ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. **Concurrent Operation with Other Programs.** This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☑ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Iowa High Quality Healthcare Initiative-Submitted

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

☑ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☑ **§1915(b)(3) (employ cost savings to furnish additional services)**

☑ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. **Dual Eligiblity for Medicaid and Medicare.**

Check if applicable:

☑ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

Amendment Summary

This §1915(c) amendment is being submitted concurrently with a §1915(b) waiver application to implement the Iowa High Quality Healthcare Initiative (the "Initiative"). Specific authorities requested will allow the State to require the majority of Medicaid beneficiaries to receive their nursing facility, hospice, home and community based services (HCBS) and physical and behavioral health services through managed care organizations (MCOs) selected by the State through a competitive procurement process.

The State will contract with a minimum of two, and not more than four, MCOs thereby ensuring members have the choice between entities. Further, members will receive choice counseling from an Enrollment Broker to assist in plan selection. Once a member is enrolled with an MCO he or she will have access to the State's Fair Hearing process, after exhausting the MCO's appeals system. Members can continue services while an appeal decision is pending, when the conditions of 42 CFR 438.420 are met. Additionally, the State will have an Independent Advocate or Ombudsman services available to members to assist with understanding rights, responsibilities and handling of disputes and grievances. MCOs will be responsible for critical incident reporting and management in accordance with State requirements, as well as convening a Stakeholder Advisory Board to engage consumers, their representatives, and providers. The State will ensure compliance with all managed
care regulations set forth in 42 CFR §438, unless otherwise waived, and that capitation rates are developed and certified as actuarially sound, pursuant to 42 CFR §438.6.

Certain waiver participants, as described in the §1915(b) waiver will not be eligible for managed care and will therefore continue to receive services through a fee-for-service delivery system. Participants ineligible for managed care will receive services through those processes currently in place for HCBS services, whereby the State is responsible for service plan development, care management, provider network management, utilization management, reimbursement of providers, quality oversight, etc.

Given the two distinct delivery systems under which this waiver will operate, this waiver narrative will refer to beneficiaries as: (1) "members," in the case of those being served by a managed care organization; or (2) "fee-for-service participants," in the case of those being served by the State. In those instances where the State provides a service or function on behalf of all beneficiaries regardless of delivery system, the waiver narrative will refer to "participants," generally. Further, MCOs will be required to adhere to all state policies, procedures, and regulations regarding waiver services including, but not limited to, responses provided in this waiver application.

Waiver Program Summary

The goal of the Iowa HCBS Children's Mental Health (CMH) waiver is to provide community alternatives to institutional services. Through need-based funding of individualized supports, eligible participants may maintain their position within their homes and communities rather than default placement within an institutional setting. The Iowa Department of Human Services (DHS) Iowa Medicaid Enterprise (IME) is the single state agency responsible for the oversight of Medicaid.

Individuals access waiver services by applying to their local DHS office or through the online DHS benefits portal. Each individual applying for waiver services must meet hospital facility level of care (i.e., inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160). IME's Medical Services Unit (MSU) is responsible for determining the initial level of care assessments for all applicants, and level of care revaluations for fee-for-service participants. MCOs are responsible for conducting level of care reevaluations for their members, with IME having final review and approval authority for all reassessments that indicate a change in the level of care. Further, the MCOs are responsible for developing and implementing policies and procedures for ongoing identification of members who may be eligible for waiver services. In the event there is a waiting list for waiver services at the time of initial assessment, applicants are advised of the waiting list and that they may choose to receive facility-based services.

If the applicant is deemed eligible, necessary services are determined through a person centered planning process with assistance from an interdisciplinary team. After exploring all available resources, including natural and community supports, the individual will have the option to choose between various traditional and self-directed services.

Services include environmental modifications and adaptive devices; family and community supports; in-home family therapy; and respite.

Through increased legislative focus of appropriations, mental health and disability services redesign, and infrastructure development through Iowa's Balancing Incentives Payment Program, it is the goal of Iowa to offer a more uniform and equitable system of community support delivery to individuals qualifying for waiver services.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. **Waiver Administration and Operation. Appendix A** specifies the administrative and operational structure of this waiver.

B. **Participant Access and Eligibility. Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. **Participant Services. Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. **Participant-Centered Service Planning and Delivery. Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. **Participant-Direction of Services.** When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- ○ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ◉ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. **Participant Rights. Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. **Participant Safeguards. Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. **Quality Improvement Strategy. Appendix H** contains the Quality Improvement Strategy for this waiver.

I. **Financial Accountability. Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. **Cost-Neutrality Demonstration. Appendix J** contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. **Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B.**

B. **Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ◉ **Not Applicable**
- ○ **No**
- ○ **Yes**

C. **Statewideness.** Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- ◉ **No**
- ○ **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.

Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. **Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. **Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. **Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. **Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. **Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. **Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. **Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. **Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. **Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. **Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. **Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. **Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. **Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. **Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. **FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. **Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s)

of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. **Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. **Public Input.** Describe how the State secures public input into the development of the waiver:
Given character limitations within the CMS Waiver Management System, a summary of the State's public comment process and any waiver edits has been included in the Main Module, 8.B, "Additional Needed Information (Optional)." This information is also available online at http://dhs.iowa.gov/ime/about/initiatives/MedicaidModernization. In addition, DHS seeks continuous and ongoing public input through a variety of committees and organizations. Specifically, the Iowa Developmental Disability Council meets bi-monthly and provides input as necessary. DHS has appointed one staff person from the IME Long Term Care Unit to the Council, which includes various stakeholders including participants and families, providers, case managers, and other State departments. IME is also invited to attend a number of association and advocacy group meetings (i.e., Iowa Association of Community Providers, Iowa State Association of Counties, Iowa Health Care Association, and Olmstead Task Force) to provide and seek feedback on service planning, cost reporting, quality assurance documentation requirements, and case management issues. Further, the public has the opportunity to comment on Iowa Administrative rules and rule changes through the public comment process, the Legislative Rules Committee, and the DHS Council.

J. **Notice to Tribal Governments.** The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. **Limited English Proficient Persons.** The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name: LeAnn

First Name: Howland

Title: Program Manager

Agency: Iowa Department of Human Services

Address: 100 Army Post Road

Address 2:

City:

Des Moines

State: Iowa

Zip:

50315

Phone:

(515) 256-4624 Ext: ☐ TTY

Fax:

(515) 725-1360

E-mail:

lhowlan@dhs.state.ia.us

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: Iowa

Zip:

Phone:

Ext: ☐ TTY

Fax:

E-mail:

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the State's request to amend its approved waiver under §1915(c) of the Social Security Act. The State affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The State further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The State certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

State Medicaid Director or Designee

Submission Date:

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: Iowa

Zip:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☑ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**

- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

The submitted amendment seeks to implement a managed care delivery system concurrent with the State's §1915(b) Iowa High Quality Healthcare Initiative waiver. All HCBS enrollees, regardless of delivery system, will be afforded the same services, rights, and safeguards as they are today. The primary difference between the approved waiver and the submitted amendment is the delineation of responsibility between the State and contracted MCOs, as the State has explicitly proscribed the manner in which services shall be provided to enrollees. The State will maintain responsibility for all enrollee level of care determinations. There are no limitations on the amount of waiver services in the proposed waiver that did not exist in the approved waiver.

Participants will be notified of delivery system changes through a comprehensive statewide communications strategy and will be provided enrollment assistance through a variety of means including by phone, in writing, or through an authorized representative. In addition, the state has developed partnerships with advocacy organizations (e.g., Area Agencies on Aging) to assist beneficiaries with enrollment and these organizations will also provide on-site assistance. In-person assistance by the State will be provided for beneficiaries with special healthcare needs who are unable to avail themselves of the traditional resources.

Procedures for offering participants an opportunity to request a fair hearing are outlined in significant detail in Appendix F-1 of the submitted amendment. In addition, the Iowa Department on Aging (IDA) is responsible for operating the Office of the State Long-Term Care Ombudsman (OSLTCO) which, in addition to advocating for residents of nursing facilities, residential care facilities, and tenants of assisted living programs and elder group homes, will utilize its resources to provide assistance and advocacy services to eligible recipients, or the families or legal representatives of such eligible recipients, of long-term services and supports provided through the Medicaid program.

OSLTCO assistance and advocacy includes but is not limited to: (1) assisting recipients in understanding the services, coverage, and access provisions and their rights under Medicaid managed care; (2) developing procedures for the tracking and reporting of the outcomes of individual requests for assistance, the obtaining of necessary services and supports, and other aspects of the services provided to eligible recipients; and (3) providing advice and assistance relating to the preparation and filing of complaints, grievances, and appeals of complaints or grievances, including through processes available under managed care plans and the state appeals process, relating to long-term services and supports under the Medicaid program.

Finally, Section 8.15.1 Iowa's MCO Contracts, Special Terms Appendix 1 – Scope of Work requires MCOs to "inform members of their grievance, appeal, and State fair hearing rights in member enrollment materials," and to direct all member eligibility and eligibility related grievances and appeals (including but not limited to long-term care eligibility and enrollment), including termination of eligibility, effective dates of coverage, and the determination of premium, copayment, and patient liability responsibilities to the State.

Contract performance will be monitored by a state employed contract manager assigned to the MCO. Contract managers are responsible for ensuring that the MCO meets its contractual obligations within the stated timeframes. Regarding grievances, each MCO is contractually required to resolve one hundred percent of grievances within thirty calendar days of receipt, or within three business days of receipt for expedited grievances. The MCO must also maintain and report to the State a member grievance log that includes the current status of all grievances. Regarding appeals, each MCO is contractually required to resolve one hundred percent of appeals within forty-five calendar days of receipt, or within three business days of receipt for expedited appeals. One hundred percent of appeals must be acknowledged within three business days. Each MCO must maintain and report to the State a member appeal log that includes the current status of all appeals.

Statewide MCO enrollment in the Initiative will be effective April 1, 2016. As such, the State will begin accepting MCO

selections from current Medicaid enrollees beginning in fall 2015. To facilitate the MCO selection process, enrollees will receive enrollment notices that include a tentative MCO assignment based on an algorithm designed to: (1) deal the population evenly among the MCOs; and (2) assign all members of a particular family to the same MCO. As all MCOs are required to extend contract offers to all current Iowa Medicaid enrolled providers, existing provider-beneficiary relationships should be available as the program is implemented. The notice will also include information regarding all available MCO options and will provide the opportunity for enrollees to make an alternative selection prior to the tentative assignment becoming effective. The Enrollment Broker will take MCO selections and provide choice counseling to assist enrollees. Enrollees will be fully enrolled based on their tentative assignment in the absence of an alternative choice made by the required response date listed in the notice. Once fully enrolled, members will have the opportunity to change MCOs in the first 90 days of enrollment without cause. The timeline for sending these notices will be staggered based on Medicaid eligibility groups. To permit additional time and assistance for members receiving long-term services and supports, these notices will first be sent to individuals in an institution, individuals enrolled in a §1915(c) waiver, and individuals receiving §1915i home and community
based services under the Iowa Medicaid State Plan.

Those participants who have not made an MCO selection, or who are otherwise ineligible for managed care enrollment as defined in the Iowa High Quality Healthcare Initiative §1915(b) waiver, will continue to receive services through fee-for-service delivery system.

Within five (5) business days of receipt of member enrollment information, MCOs will distribute enrollment materials to each member. All information will be provided to members with limited English proficiency through the provision of language services at no cost to the individual. All written materials will be provided in English and Spanish, and any additional prevalent languages identified by the State, and will be made available in alternative formats that take into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency (e.g., 508 compliance, Braille, large font, audiotape and verbal explanations of written materials). All members and potential members will be informed that information is available in alternative formats and how to access those formats.

Enrollment materials will include, but not be limited to, provider directory information and/or information on how to find a network provider near the member's residence, the MCO's contact information, the amount, duration, and scope of covered services, information regarding the availability of Member Helpline and 24-hour Nurse Call Line, procedures for obtaining benefits, a description of any restrictions on the member's freedom of choice among network providers, and information on the grievance and appeal process. Specific information regarding waiver services will include a description of the community based case management's or integrated health home's role and responsibilities, information on how to change community based case management or integrated health homes, and when applicable, information on the option to self-direct.

For those participants transitioning from fee-for-service to managed care, MCOs will implement a comprehensive strategy, subject to State approval, to ensure a seamless transition of services during program implementation. Strategies will include timelines within which all members receiving 1915(c) waiver services will receive an in-person visit from appropriate MCO staff and an updated needs assessment and service plan. Services will not be reduced, modified or terminated in the absence of an up-to-date assessment of needs that supports the reduction, modification or termination.

MCOs will also ensure that members are permitted to see all current providers on their approved service plan upon initial enrollment, even on a non-network basis, until a service plan is completed and agreed upon by the member or resolved through the appeals or fair hearing process, and implemented. MCOs will extend the authorization of waiver services from a nonnetwork
provider as necessary to ensure continuity of care pending the provider's contracting with the MCO, or the member's transition to an in-network provider. MCOs will be responsible for facilitating a seamless transition to new services and/or providers, as applicable, in the plan of care developed by the MCO without any disruption in services. Further, MCOs are contractually required to extend DHS enrolled 1915(c) HCBS waiver providers an opportunity to be part of its provider network.

MCOs will implement plans, subject to State approval, to provide seamless, effective transition from the member's former targeted case manager, case manager, or service worker (as applicable), and any change in community-based case management. MCOs will allow members to retain their current case manager during the first six months of transition. All transition plans will be fully implemented within one year.

DHS will provide data sharing with MCOs to assist in continuity of care, including providing prior authorizations in place at the time of member transition, claims history and service plans. Further, DHS will implement oversight strategies to ensure

MCO compliance with continuity of care requirements, including, but not limited to, readiness review and regular reporting.

DHS and the MCOs will also implement strategies to assist providers in the transition. DHS strategies will include educational sessions and the provision of written materials such as frequently asked questions and provider bulletins. MCOs are contractually required to implement provider communication strategies which will assist in provider transition such as publication of a provider manual, maintenance of a provider website, operation of a provider services helpline, and extensive provider training.

DHS and the MCOs will also implement a comprehensive member and stakeholder education and engagement strategy to assist in transition, ensure understanding of the program and promote a collaborative effort to enhance the delivery of high quality services to members. DHS operates an Managed Long Term Services and Supports (MLTSS) Advisory Group for long-term services and supports recipients and stakeholders. Further, the MCOs are contractually required to operate a Stakeholder Advisory Board which is charged with providing input on issues such as: (i) service delivery; (ii) quality of care; (iii) member rights and responsibilities; (iv) resolution of grievances and appeals; (v) operational issues; (vi) program monitoring and evaluation; (vii) member and provider education; and (viii) priority issues identified by members.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.
Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.
To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301 (c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

Iowa assures that the settings transition plan included with this waiver amendment will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. The State will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

Public comment was taken from March 4, 2015 through April 3, 2015. The entire waiver including the settings transition plan was posted on the Iowa Medicaid Enterprise (IME) website at: http://dhs.iowa.gov/ime/about/initiatives/HCBS/waiver-amend. Public notice in a non-electronic format was done by publishing a notice in major newspapers throughout the state; this notice
was sent to the newspapers on February 26, 2015. The full waiver documents and transition plan were available for nonelectronic viewing in any of the 99 DHS office across the state for persons who may not have internet access. Comments were accepted electronically through a dedicated email address (HCBSsettings@dhs.state.ia.us). The address was provided for written comments to be submitted to the IME by mail or by delivering them directly to the IME office. Notice was also sent to the federally-recognized tribes on February 26, 2015.

Summary of Comments:
No comments pertaining to the waiver amendment were received; as such, no modifications were made to the waiver.

The Transition plan specific to the CMH Waiver is found on the DHS website: https:
https://dhs.iowa.gov/sites/default/files/CMH%20Waiver%20Settings%20Transition%20Plan.pdf. and includes the following:

Section 1: Assessment
Iowa proposes a multifaceted approach to assessment. This will include the completion of a Settings Analysis, which will be a high-level assessment of settings within the state to identify general categories (not specific providers or locations) that are

likely to be in compliance; not in compliance; presumed to be non-HCBS; or those that are not yet, but could become compliant. Other avenues for assessment will include identifying HCBS settings during provider enrollment and re-enrollment; evaluating settings through the existing HCBS quality assurance onsite review process and the provider self-assessment process; and monitoring of Iowa Participant Experience Survey (IPES) results for member experiences. Assessment activities will be incorporated into current quality assurance processes to the extent possible.

All MCOs contracting with the State to provide HCBS are required to ensure non-institutional LTSS are provided in settings which comport with the CMS HCBS requirements defined at 42 CFR 441.301(c)(4) and 42 CFR 441.710(a). MCOs will be required to ensure compliance through the credentialing and monitoring of providers and service authorization for waiver participants.

10/1/2014 - 10/31/2014: Settings Analysis - State identified HCBS settings as they potentially conform to HCBS characteristics and ability to comply in the future. General settings are classified into categories (Yes - settings fully compliant, Not Yet - settings that will comply with changes, Not Yet - setting is presumed non-HCBS but evidence may be presented for
heighted scrutiny review, and No - setting do not comply) The Iowa HCBS Settings Analysis is being submitted as one component of the transition plan.
12/1/2014 - 12/31/2014: Provider Enrollment Processes - State will operationalize mechanisms to incorporate assessment of settings into existing processes for provider pre-enrollment screening by the Iowa Medicaid Enterprise (IME), provider credentialing by the managed care behavioral health organization (BHO), and HCBS provider certification by the HCBS Quality Oversight unit.
5/1/2015 - 12/31/2015: Geographic Information System (GIS) Evaluation of HCBS Provider Locations and HCBS Member Addresses - State will use GIS to analyze locations of provider sites and member addresses to identify potential areas with high concentration of HCBS.
12/1/2014 - ongoing: Onsite assessment - The State will incorporate review of settings into the review tools used by the HCBS Quality Oversight Unit for on-site reviews. Settings will be assessed during recertification reviews, periodic reviews, focused reviews, and targeted reviews. State will identify providers with sites of service that have the characteristics of HCBS or the
qualities of an institution.
10/1/2014 - ongoing: Enrolled HCBS providers self-assessment - The state will modify the Provider Quality Management Self-Assessment to identify HCBS sites and to gather additional information from providers to assess sites of service that have characteristics of HCBS or the qualities of an institution. The annual self-assessment will be released to providers annually on October 1 and due to IME annually on December 1, with results compiled by February 28. The State will release the "Iowa Exploratory Questions for Assessment of HCBS Settings" document to assist providers in identifying the expected characteristics of HCBS.
8/1/2014 - ongoing: Other projects collecting HCBS setting data - State provider association will provide information and input from residential providers to the state.
12/1/2014 - ongoing: Iowa Participant Experience Survey (IPES) - State will continue to monitor IPES results to flag member experience that is not consistent with assuring control over choices and community access.
5/1/2015 - By 3/17/2019: Onsite Assessment Results Report - State compiles and analyzes findings of onsite assessments annually by July 31, with the final report completed by 3/17/19. Findings will be presented to Iowa DHS leadership and stakeholders.

Section 2: Remediation Strategies
Iowa proposes a remediation process that will capitalize on existing HCBS quality assurance processes including provider identification of remediation strategies for each identified issue, and ongoing review of remediation status and compliance. The state may also prescribe certain requirements to become compliant. Iowa will also provide guidance and technical assistance to providers to assist in the assessment and remediation process. Providers that fail to remediate noncompliant settings timely may be subject to sanctions ranging from probation to disenrollment.

6/1/2014 - 7/31/2016: Informational Letters - State will draft and finalize informational letters describing proposed transition, appropriate HCBS settings, deadlines for compliance, and technical assistance availability. BHO and MCOs will provide the same information to provider network.
12/1/2014 - 7/31/2015: Iowa Administrative Code - State will revise administrative rules chapters 441-77, 78, 79, and 83, to reflect federal regulations on HCBS settings. Rules will define HCBS setting thresholds and will prohibit new sites from being accepted or enrolled that have an institutional or isolating quality while presenting deadlines for enrolled providers to come
into compliance. Rules will clarify expectations of member control of their environment and access to community. BHO and MCOs will develop the same standards for provider network.

8/1/2015 - 12/31/2015: Provider Manual Revisions - State will revise HCBS provider manual Chapter 16K to incorporate regulatory requirements for HCBS and qualities of an HCBS setting. BHO and MCOs will incorporate the same information into relevant provider network manuals.
12/1/2014 - ongoing: Incorporate Education and HCBS Compliance Understanding into Provider Enrollment - IME Provider Services Unit Pre-Enrollment Screening process will make adjustments to ensure that HCBS settings are evaluated when appropriate. When agencies enroll to provide HCBS services, they will be provided information on HCBS setting requirements and be required to certify that they have received, understand, and comply with these setting requirements.
12/1/2014 - ongoing: Provider Assessment Findings - State will present each provider with the results of the assessment of their organizational HCBS settings as findings occur throughout the assessment process.
12/1/2014 - 3/16/2019: Provider Individual Remediation - HCBS providers will submit a corrective action plan (CAP) for any settings that require remediation. The CAP will provide detail about the steps to be taken to remediate issues and the expected timelines for compliance. The state will accept the CAP or may ask for changes to the CAP. The state may preset remediation requirements for each organization's HCBS settings. Providers will be required to submit periodic status updates on
remediation progress. State review of CAPs will consider the scope of the transition to be achieved and the unique circumstances related to the setting in question. The state will allow reasonable timeframes for large infrastructure changes with the condition that the providers receive department approval and provide timely progress reports on a regular basis. Locations presumed to be non-HCBS but which are found to have the qualities of HCBS will be submitted to CMS for heightened scrutiny review.
12/1/2014 - 3/16/2019: Data Collection - State, BHO, and MCOs will collect data from reviews, technical assistance, updates, etc. to track status of remediation efforts. Data will be reported on a regular basis or ad hoc to DHS management and CMS.
12/1/2014 - 3/1/2019: Onsite Compliance Reviews - State will conduct onsite reviews to establish levels of compliance reached by providers with non-HCBS settings following completion of their remediation schedule.
12/1/2014 - 3/16/2019: Provider Sanctions and Disenrollments - State will disenroll and/or sanction providers that have failed to meet remediation standards. State will disenroll and/or sanction providers that have failed to cooperate with the HCBS Settings Transition.
12/1/2014 - 3/16/2019: Member Transitions to Compliant Settings - If relocation of members is necessary, the state will work with case managers, service workers, and care coordinators to ensure that members are transitioned to settings meeting HCBS Setting requirements. Members will be given timely notice and due process, and will have a choice of alternative settings through a person centered planning process. Transition of members will be comprehensively tracked to ensure successful placement and continuity of service.

Section 3: Public Comment
Iowa proposes to collect public comments on the transition plan through a dedicated email address for submission of written comments, and through taking public comments directly by mail. Iowa has also previously held a comment period in November 2014 which included solicitation of comments through stakeholder forums. In addition to posting the transition plan and related materials on the Iowa Medicaid website, numerous stakeholders were contacted directly and provided with transition plan documents and information on the stakeholder forums. Stakeholders contacted include Disability Rights Iowa, the Iowa Association of Community Providers, the Iowa Health Care Association/Iowa Center for Assisted Living, Leading Age Iowa, the Iowa Brain Injury Association, the Olmstead Consumer Task Force, the Iowa Mental Health and Disability Services Commission, the Iowa Developmental Disabilities Council, NAMI Iowa, ASK Resource Center, Area Agencies on
Aging, County Case Management Services, and MHDS Regional Administrators.

3/9/2015 - 3/13/2015: Announcement of Public Comment Period - State released a White Paper, the Draft Transition Plan, and Draft Settings Analysis on the state website. Informational Letters were released and sent to all HCBS waiver providers, case managers and DHS service workers. Stakeholders (listed above) were contacted directly to inform them of the public comment period. A dedicated email address (HCBSsettings@dhs.state.ia.us) was established to receive public comments. Tribal notices were sent. Notices were filed in newspapers. Printed versions were made available in DHS local offices statewide, along with instructions on submitting comments via mail.
3/16/2015 - 4/15/2015: Public Comment Period for Proposed Transition Plan - State will share transition plan with the publicin electronic and non-electronic formats, collect comments, develop state responses to public comments, and incorporate appropriate suggestions into transition plan. The Response to Public Comments document will be posted to the DHS website and a summary provided to CMS. Previous comment periods were held in May 2014 and November 2014 which included
stakeholder forums.
4/15/2015 - 3/16/2019: Public Comment Retention - State will safely store public comments and state responses for CMS and public consumption.

4/15/2015 - 3/16/2019: Posting of Transition Plan Iterations - State will post each approved iteration of the transition plan to its website.
7/1/2015 - By 3/17/2019: Assessment Findings Report - State shares the findings of the onsite assessment annually by July 31.

Iowa HCBS Settings Analysis - This Settings Analysis is general in nature and does not imply that any specific provider or location is noncompliant solely by classification in this analysis. Final determination will depend upon information gathered through all assessment activities outlined in the transition plan, including but not limited to onsite reviews, provider annual self-assessments, IPES data, provider surveys, and GIS analysis.
Category: YES – Settings presumed fully compliant with HCBS characteristics
--Member owns the housing, or leases housing which is not provider owned or controlled.
Category: NOT YET – Settings may be compliant, or with changes will comply with HCBS characteristics
--Apartment complexes where the majority of residents receive HCBS
Category: NOT YET - Setting is presumed non-HCBS but evidence may be presented to CMS for heightened scrutiny review
--Located in a building that also provides inpatient institutional treatment
--Any setting on the grounds of or adjacent to a public institution
--Settings that isolate participants from the broader community
Category: NO – Settings do not comply with HCBS characteristics
--Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/ID) (except Respite)
--Nursing Facilities/Skilled Nursing Facilities
--Hospitals
--Institutions for Mental Disease (IMD)

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Iowa High Quality Healthcare Initiative
Public Comment Summary

I. Background

The Iowa Department of Human Services (DHS) has continually sought to improve Medicaid and the Children's Health Insurance Program (CHIP) and beneficiary choice, accountability, quality of care, and health outcomes. DHS has also encouraged the provision of community-based services over institutional care where appropriate. The State seeks to build on its experience and improve the coordination of care, which is often available at different points throughout the Medicaid eligibility cycle and patient experience, through implementation of the Iowa High Quality Healthcare Initiative (Initiative). In recent months, this Initiative has also been referred to publicly as the Governor's "Medicaid Modernization Initiative."

The Initiative is intended to integrate care and gain efficiencies across the health care delivery system. In turn, the Initiative intends to decrease costs through the reduction of unnecessary and duplicative services. Under the Initiative, the majority of Iowa Medicaid beneficiaries will be enrolled in a managed care organization (MCO). MCOs are private health care organizations that provide and pay for health care services through an organized network of providers. MCOs use established guidelines to assure member services are appropriate and delivered at the right time, in the right way, and in the right setting. By contracting with MCOs for delivery of high quality health care services, beneficiaries' care will be better coordinated, resulting in improved access, quality, and health outcomes.

On February 16, 2015, DHS released a preliminary Request for Proposals (RFP) for the Initiative. This release was followed by the development of a dedicated web page, and a series of public meetings to discuss the Initiative (http://dhs.iowa.gov/ime/about/initiatives/MedicaidModernization). Stakeholders and members of the public were invited to attend meetings held in Cedar Rapids, Des Moines, Davenport, Iowa City, Council Bluffs, Mason City, and Sioux City. In total, close to 1,000 people attended and provided DHS with valuable comments and questions. This public engagement strategy was intended to solicit stakeholder feedback on key program design elements and MCO contract requirements. On March 26, 2015, the DHS released an amended version of the RFP which incorporated changes based on stakeholder feedback.

II. Federal Authorities

DHS is working with the Centers for Medicare and Medicaid Services (CMS) to obtain the necessary federal authority to implement the Initiative. This requires submission of a variety of federal Medicaid waivers and amendments, noted below.

§1915(b) Iowa High Quality Healthcare Initiative Waiver (New Waiver)
§1915(c) HCBS Intellectual Disabilities Waiver (Amendment)
§1915(c) HCBS Children's Mental Health Waiver (Amendment)
§1915(c) HCBS Elderly Waiver (Amendment)
§1915(c) HCBS Health & Disability Waiver (Amendment)
§1915(c) HCBS Physical Disability Waiver (Amendment)
§1915(c) HCBS Brain Injury Waiver (Amendment)
§1915(c) HCBS AIDS/HIV Waiver (Amendment)
§1115 Iowa Wellness Plan Demonstration Waiver (Amendment)
§1115 Family Planning Demonstration Waiver (Amendment)

Prior to submission of the aforementioned waivers, the State elected to conduct a public notice and comment process. At the beginning of this process, four of the State's §1915(c) waivers were pending review by CMS for matters unrelated to the Initiative. As such, the State has broken down the process into three "phases." However, managed care elements were consistent across all §1915(c) waivers. Notices, waiver documents, and information about the Initiative were posted online, and non-electronic copies were made available for review at DHS Field Offices, for each "phase." In addition, a summary notice was published in several newspapers with statewide circulation. The notice provided the option for any individual to submit written feedback to the State by email or by USPS mail.

Phase 1

Public notice for Phase 1 was provided on July 20, 2015, and included the following waivers: (1) §1915(b) High Quality Healthcare Initiative Waiver (New Waiver); (2) §1915(c) HCBS Intellectual Disabilities Waiver (Amendment); (3) §1915 (c) HCBS Children's Mental Health Waiver (Amendment); (4) §1915(c) HCBS Elderly Waiver (Amendment); (5) §1115 Iowa Wellness Plan Demonstration Waiver (Amendment); and (6) §1115 Family Planning Demonstration Waiver (Amendment).

In addition, the State held four public hearings during Phase 1 to offer an opportunity for the public to provide written or verbal comments about the above-mentioned waivers. Hearings were held on July 27, 2015 (Bettendorf, IA), July 31, 2015 (Des Moines, IA), August 3, 2015 (Cedar Rapids, IA), and August 5, 2015 (Sioux City, IA). Toll free conference call capabilities were made available for the August 3rd and 5th dates in order to accommodate interested parties who were unable to attend a hearing in person. Hearings followed the same format, beginning with a brief presentation by State staff about the Initiative, a short question and answer session, and at least one hour of public comments. Time permitting, State staff fielded additional questions at the end of the hearing. The public comment period ended on August 24, 2015 (35-days from the date of publication), at which time comments were cataloged, summarized, and organized.

Tribal Consultation

The State also consulted with Iowa's federally recognized Indian tribes, Indian health programs, and urban Indian health organizations prior to submission of the waivers. Consultation was conducted in accordance with the process outlined in the State's approved Medicaid State Plan, and consisted of an electronic notice directed to Indian Health Service/Tribal/Urban Indian Health (I/T/U) Tribal Leaders and Tribal Medical Directors identified by the Iowa Indian Health Services Liaison. This notice was provided concurrently with notice of each phase described above and included a copy of the proposed amendment, along with a description of how and where to submit comments or questions.

III. Public Comments – Phase 1

Throughout the Phase 1 public comment period, a total of 162 questions and comments were received (51 questions, 42 verbal comments, and 69 written comments). Very few comments were waiver specific, as the vast majority were aimed at the Initiative in general. Of these questions and comments, a broad range of topics were addressed including case management, service delivery/access, home and community based services, MCO oversight/evaluation, eligibility/included benefits, provider issues, enrollment, member choice, outreach, implementation timeline, reimbursement, quality/safety, MCO standardization.

a. Program Questions

Comments Received:

During the public comment process, many individuals took the opportunity to ask questions related to program design and the implementation process. These questions were not specific to the Initiative or the waivers open for public comment; rather they sought clarification from the State. Individuals raised a variety of general questions around the following general themes: (1) 1915(c) HCBS waiver assessment process; (2) MCO selection, assignment and change processes and timelines; (3) implementation member outreach processes; (4) out-of-network providers policies and procedures around selecting a provider; (5) funding and authorization rules; (6) State MCO procurement process; (7) impact to eligibility; (8) clarification on the waiver public comment process; (9) provider roles and responsibilities; (10) reimbursement rates; (11) MCO operational processes; (12) case manager roles and qualifications; (13) MCO quality oversight processes; (14) level of care assessment procedures; (15) provider enrollment processes; and (16) clarification regarding FQCH & RHC reconciliation process and prospective payment system wrap payments.

§1915(b) Waiver Specific Questions:

In addition, to the above program-related questions several specific questions were raised requesting additions to the §1915 (b) waiver: (1) ensure clarity regarding the 340B drug-pricing program; (2) allow all current Marketplace Assisters to provide state-supported services to Medicaid MCO beneficiaries; (3) include additional §1915(b)(3) services (e.g., telemedicine), as identified through a public input process; and (4) include a waiver measurement that addresses disparities by racial or ethnic group.

State Response:

Because the program questions did not provide specific feedback on the waivers, no modifications were made to the waivers. These general themes will be utilized by the State to continue developing communication materials and to inform the transition process. With respect to the 340B drug-pricing program, the State feels this would be best addressed through MCO contracting and will take the commenters suggestion into consideration during this process. Regarding Iowa Marketplace Assisters, the State views Assisters as valuable community partners. As such, the State will provide Assisters with information and education about the transition to managed care as part of the stakeholder engagement strategy. This information will provide the tools needed to help inform and refer Medicaid members the Assisters may have contact with to the Medicaid Enrollment Broker, Iowa Medicaid Enterprise Member Services (MAXIMUS). Finally, additional the State will take commenters request for the provision of additional §1915(b)(3) under advisement for future waiver amendments. The state will incorporate into its final waiver submission the recommended waiver measurement.

b. Case Management

Comments Received:

Several comments were received related to case management. Generally, commenters expressed the importance of case management being provided in a conflict free manner and without incentives for MCOs to cut services; several commenters perceived that case management provided through an MCO would not be conflict free. There were concerns that MCO case managers would not advocate for members and members were not guaranteed to have continued access to their current case manager. Commenters questioned if there would be enough qualified case managers to serve beneficiaries following the transition. Additionally, two current case managers raised concerns over their future employment status. Another commenter suggested the new program would provide an opportunity to improve the system that is currently difficult to navigate.

State Response:

The Initiative will continue case management services through the MCOs. MCOs are contractually required to ensure the delivery of services in a conflict free manner consistent with Balancing Incentive Program requirements and which administratively separates the final approval of service plans and approval of funding amounts. The State will approve and monitor all MCO policies and procedures through the readiness review and ongoing quality assurance processes, and ensure compliance and swiftly implement corrective actions in this area as needed. With respect to the number of qualified case managers available to provide services following implementation, DHS anticipates that the overall number of Medicaid beneficiaries will not materially change during the transition to managed care and that the overall system will continue to have the capacity to provide case management services to all beneficiaries regardless of delivery mechanism (i.e., managed care or fee-for-service), as they do today. The implementation plan for the Initiative allows members to retain their current

case manager during the first six months of transition, regardless of whether the MCO has an agreement with the member's existing case manager. Following this six-month period, MCOs must provide advance notice of planned case manager changes, and must ensure continuity of care when such changes are made. For those beneficiaries remaining in fee for service, DHS will maintain existing contracts to ensure sufficient numbers of case managers are available to meet the needs of beneficiaries.

c. Service Delivery/Access

Comments Received:

Several comments were received related to service delivery and access. Generally, commenters expressed concern that MCOs may prioritize profit over services, which will jeopardize member health and safety, and that members with disabilities and/or serious health conditions may no longer receive the attention and care they require. One commenter expressed support that MCOs would be required to contract with the current Medicaid providers. Finally, one commenter suggested that the State extend the transition of care period (i.e., the period during which patients are allowed to keep their existing provider) from six months to a year.

State Response:

The Initiative has been designed to incorporate mechanisms to ensure State funding to MCOs is spent on the delivery of services to enrollees and that quality outcomes are achieved. For example, home and community based services waiver metrics include, among other things, an assessment of whether enrollees received the all of the services outlined in their plan of care and a review of whether waiver provider enrollment applications were verified against appropriate licensing and/or certification agencies. Further, the State may require corrective action(s) and implement intermediate sanctions depending upon the nature, severity, and duration of the deficiency, and repeated nature of the non-compliance. Additionally, MCOs will have a portion of their State payments withheld; payment of the withhold amount can only be obtained by the MCO if it achieves defined quality outcomes. The State will also establish escalating targets for each quality measure in future years of the program. This means if MCOs do not achieve better results each year they will not be eligible for payment of their withheld amounts. Additionally, the State has established a medical loss ratio (MLR) to ensure State funding is spent on the delivery of services to members. An MLR caps the portion of State dollars that can be spent by the MCO on non-healthcare related services such as administration, marketing, and profits. The State will recoup funding if an MCO does not meet the required MLR. No changes have been made to the waivers as a result of these comments. With respect to extending the transition of care period, the State will be monitoring and assessing provider networks on an ongoing basis post implementation to ensure that beneficiaries' continuity of care for beneficiaries transitioning to managed care, as well as ongoing member access.

d. Home and Community Based Services (HCBS)

Comments Received:

Multiple comments were received related to the provision of home and community based services (HCBS). Commenters expressed the importance of emphasizing HCBS over institutional services. They indicated there should be requirements and incentives for MCOs to move the State toward supporting community integration and suggested future cost savings be used to increase access to HCBS. However, it was also noted that there are access issues for community-based services that will prevent such movement. Also related to access, one commenter expressed concern that provider access would be compromised if MCOs were allowed to limit HCBS providers. Further, one commenter was concerned the Initiative would strive to move enrollees to individual apartments and out of group homes. One commenter also questioned how individuals residing in group homes would be impacted if residents were enrolled with different MCOs.

Commenters also discussed the importance of MCOs involving and partnering with family caregivers for HCBS waiver enrollees. Support for the Consumer Choices Option was expressed and individuals wanted this maintained under managed care.

Multiple comments were received related to HCBS waiver waiting lists. Specifically, commenters suggested waiver waiting lists be eliminated, or additional waiver slots added. Alternatively, it was proposed waiver enrollees be excluded from managed care until there is no waiting list. Another commenter raised the concern the MCOs would eliminate waiver slots. One commenter expressed concern with the current process for managing the waitlist and suggested individuals have a functional assessment completed upfront to prevent ineligible individuals from being placed on the waiting list. Other commenters indicated HCBS waiver enrollees should be excluded from managed care enrollment; they pointed to current

strategies, which already manage waiver enrollee care, such as proposed rules for implementing budget caps.

Comments were received regarding provider types that should be eligible HCBS waiver providers. Commenters indicated Home Care Agencies should be added as an eligible provider type, which includes providers who meet the definition of an authorized provider under 641 Iowa Administrative Code 80.2(135). Another commenter indicated language regarding home care agencies should be removed, as IDPH is no longer contracting for homemaker services. Additionally, one commenter suggested the Area Agencies should not be allowed to provide services in areas where there are at least two other providers and that having the Area Agencies maintain case managers is a conflict of interest. Another commenter suggested Medicare/Medicaid certification should not be required to provide homemaker services to members. Further, comments were received related to the assessment process. One commenter indicated members already undergo extensive assessments and the results of those should be used. Another commenter expressed concern over the perception that the assessment process would no longer be uniform. Another commenter noted that the waiver and MCO request for proposals do not reference 441 Iowa Administrative Code Chapter 24, and that the amount of time a waiver enrollee is visited does not match the current regulation. Finally, one commenter expressed concern that Integrated Health Homes and BHIS were not mentioned in the waivers.

Children's Mental Health Waiver Specific Comments:

One commenter requested that the consumer choices option (CCO) be added to the waiver.

State Response:

The State shares commenters' commitment to the emphasis on HCBS versus institutional care. This is one benefit of managed care as incentives are provided to move individuals into the community; as such, the number of individuals served under the waivers is projected to increase under the Initiative. The Initiative also strives to support and increase HCBS provider access; MCOs are held accountable for meeting contractual requirements for HCBS access standards and must authorize out-of-network care when it cannot be provided in-network. Additionally, DHS concurs with commenters' support of the Community Choices Option; as such, this is a key component of the program that MCOs must implement, where applicable. While the State appreciates the concerns raised regarding inclusion of §1915(c) waiver enrollees, our belief is managed care will provide better integrated care with one single entity responsible for providing all services, including LTSS. Further, while we agree there are current management mechanisms in place for waiver enrollees, the Initiative will build upon such strategies.

With respect to eligible HCBS waiver providers, these categories are established in the Iowa Administrative Code and can only be changed through the administrative rulemaking process. The State will review and consider amendments to the list of eligible HCBS waiver providers in future rulemaking. Further, providers serving Medicaid beneficiaries, regardless of delivery system, must be enrolled with Iowa Medicaid. These certification and enrollment processes help assure qualified individuals are rendering services and provide member protections.

Regarding the references to 441 Iowa Administrative Code Chapter 24, this particular set of rules establishes case management enrollment criteria. MCOs will be required to meet the expectations in 441 Iowa Administrative Code Chapter 90, which sets forth rules for case management, including service plan requirements.

Regarding comments received on the assessment process, it appears there has been some misunderstanding regarding how the assessment process will occur under managed care. The current functional assessment tools will remain in use and MCOs cannot revise or add to the tools without express approval from the State. To the extent the State would consider proposed revisions or additions, consensus among MCOs and stakeholder engagement would be sought.

Finally, in regards to comments received on the waiting list, the State is unable to eliminate or add waiver slots at this time. With respect to available waiver slots, these numbers are increased or decreased upon direction of the Iowa Legislature through Medicaid appropriations.

e. MCO Oversight/Evaluation

Comments Received:

Several comments were received related to MCO oversight and evaluation. Generally, commenters suggested this should be conducted by an independent entity and that results should be made publically available. One commenter suggested there should be more focused quality and pay-for- performance measures related to children's health. Commenters suggested a

range of measures and factors that should be reviewed and monitored, such as network adequacy, audits of MCO claims payments, grievances and appeals, and healthcare quality outcomes. One commenter suggested the MCOs should be required to use a consistent quality measurement process.

State Response:

The State has implemented a comprehensive oversight strategy consisting of elements such as: (1) an MCO readiness review conducted by an independent entity prior to member assignment; (2) an annual external quality review; (3) an independent assessment in accordance with the §1915(b) waiver; (4) a pay-for-performance program; (5) contractual non-compliance remedies; (6) use of an Ombudsman; and (7) various quality monitoring strategies and metrics as outlined in each waiver and the MCO contracts. In addition the State is obligated to provide regular reports to CMS for §1115 Demonstration projects and §1915 HCBS waivers.

Pursuant to State legislation (Senate File 505), the Iowa Department of Human Services (DHS) will also be conducting monthly statewide public meetings, beginning March 2016, to gather input from members, stakeholders, providers, community advocates and the general public on the managed care transition and implementation. All comments will be compiled and shared with the Iowa Medical Assistance Advisory Council (MAAC), which serves as an advisory forum on the health and medical care services provided under Medicaid. The MAAC Executive Committee will be responsible for assessing feedback received and making formal recommendations to the Iowa Department of Human Services. The Executive Committee meets monthly and consists of members from both professional and consumer organizations, as well as the general public. Current organizational representation of the Executive Committee includes the Iowa Department of Public Health, the Iowa Hospital Association, the Iowa Health Care Association/Iowa Center for Assisted Living, the Iowa Medical Society, the Iowa Association of Community Providers, the Iowa Pharmacy Association, AARP, the Coalition for Family and Children's Services in Iowa, the Iowa Association for Area Agencies on Aging, and NAMI Iowa.

No changes related to the MCO monitoring, oversight or quality assessment related portions of the waivers were made as a result of these comments.

f. Eligibility/Included Benefits

Comments Received:

Several comments were received related to populations eligible for managed care. One commenter suggested the State exclude individuals who rely on plasma protein therapies or alternatively to allow such users to maintain access to current specialists and therapies. Another commenter expressed concern about the inclusion of individuals with mental health issues. A third commenter suggested the State change its position to require all MCOs to carve in Medicaid managed care prescriptions and other products into the 340B drug-pricing program. One commenter perceived the exclusion from managed care enrollment during a member's retroactive eligibility period as elimination of retroactive eligibility. Finally, one commenter suggested the State require MCOs to extend non-emergency transportation (NEMT) services to all patients, regardless of the individual Medicaid coverage program for which they qualify.

State Response:

The State has opted not to modify the eligibility criteria for managed care enrollment. MCOs are contractually bound to continuity of care requirements to prevent disruption for individuals reliant on plasma protein therapy. Further, the delivery of behavioral and physical health services by a single entity will promote coordinated care that addresses the full healthcare needs of members versus the current system which silos mental health and primary care. As a point of clarification for commenters, the State has not requested a waiver of retroactivity. Rather, individuals will simply not be enrolled in managed care during this time period and any costs incurred during retroactive periods will be reimbursed through fee-for-service. Finally, pursuant to an agreement with CMS, the State has conducted an analysis of Medicaid member survey responses on difficulties with transportation for beneficiaries subject to the Iowa Health and Wellness Plan (IHAWP) NEMT waivers as compared to survey responses of persons who have access to NEMT services. Findings of this analysis suggest there was not a statistically significant difference between the two populations; however, CMS requested an additional study supporting more granular analysis capability. As a result, the State was allowed to continue to waive NEMT services for members receiving coverage under the IHAWP (who are not medically exempt and who are not eligible for EPSDT services) through March of 2016, while additional data is gathered and analyzed.

g. Provider Issues

Comments Received:

Another theme noted among comments was the impact of the Initiative on providers and in turn the importance of ensuring sufficient provider training. One commenter requested more detailed information be included in the waivers about how the MCOs will invest and continue to build and offer new payment relationships in partnership with providers.

Some comments were received related to medical professionals versus MCOs being best suited to determine a patient's care plan and whether or not the prudent layperson standard for emergency services is met. Further, it was suggested that the State should require every patient to be assigned a primary care provider (PCP), versus the current requirement that requires a minimum of 40% of the MCO's population be in a value-based purchasing arrangement with an assigned PCP by 2018.

The concern was raised that managed care savings would come at the expense of providers. Further, one commenter noted his staff will be required to devote time to working with MCOs, a service which will not be reimbursable. Similarly, it was suggested any providers currently credentialed under Medicaid should be automatically credentialed by the MCOs. Finally, one commenter recommended the claims submission timeline be expanded.

State Response:

The State concurs that provider training will be imperative to ensure a smooth transition; plans have been developed to address provider communications, outreach and training. Further, we appreciate the request that more detailed information be provided regarding MCO strategies to develop new payment partnerships with providers; as MCO contracts have been recently awarded, these types of details can begin to be provided. The State recognizes that provider education is critical to successful implementation of the Initiative. On August 20, 2015 the State announced that it would be offering live provider education sessions on the transition to managed care in eleven different communities throughout the State during the Month of September. In an effort to meet the anticipated demand for information, the same training session will be offered twice in each community where it is presented.

Regarding the authorization of services, MCO practice guidelines must be developed based on valid and reliable clinical evidence or consensus of healthcare professionals in the particular field. Further, MCOs are required to assure appropriate clinical expertise and training to interpret and apply the utilization management criteria and practice guidelines and must consult with the requesting provider when appropriate. The MCOs must document access to board certified consultants to assist in making medical necessity determinations and any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested must be made by a physical health or behavioral health care professional who has appropriate clinical expertise in treating the member's condition or disease, or in the case of long-term care services, a long-term care professional who has appropriate expertise in providing long-term care services.

The State concurs that developing streamlined processes, such as credentialing, will be useful in some cases to minimize provider burden. However, automatic deeming of current Medicaid providers will not be implemented. To support quality, the MCOs are required to maintain national accreditation; therefore, the MCOs must maintain credentialing and re-credentialing processes that meet the standards of the accreditation entity.

h. Enrollment

Comments Received:

Several comments were received related to member enrollment. Generally, commenters expressed concern that they do not understand how the enrollment process will work, specifically whether they will have a choice in selecting MCOs, whether they will be allowed to change following enrollment and how the auto-assignment algorithm would operate. Comments revealed there was some misperception regarding how the implementation enrollment process would occur. The importance of sufficient member outreach and use of an unbiased Enrollment Broker during the implementation enrollment period was stressed by commenters. One commenter indicated it was important individuals eligible for both MCO and Program of All-Inclusive Care for the Elderly (PACE) enrollment be presented with the option to enroll in either program. Some commenters perceived the tentative assignment process as limiting member choice and creating the perception that assignment has already been made, as described in further detail in the Member Choice section below.

State Response:

The State will continue efforts to increase beneficiary understanding of the enrollment process. Communication efforts will be ramping up now that the MCOs have been selected. The State's goal is to ensure a seamless transition for current

beneficiaries and to provide ample opportunity for informed decision-making regarding MCO selection. The tentative assignment process is intended to advise members of which MCO they will be assigned to in the absence of a choice; this will provide clarity on what will occur if contact to the State is not made regarding an alternative choice. Further, the State will utilize an independent Enrollment Broker to assure no conflict of interest in the MCO enrollment and choice counseling process. The option for PACE enrollment will also be provided.

i. Member Choice

Comments Received:

Several comments were received related to member choice of MCO. In general, these commenters expressed concern that the State's proposed process to facilitate MCO selection through tentative assignment would reduce member choice. One commenter indicated that institutionalized beneficiaries would be given a choice of MCO before assignment, whereas non-institutionalized beneficiaries would not be given a choice of MCO before assignment. Another commenter suggested that in the event that two MCO options are not available, a consumer should have the opportunity to request an alternative option to receive services and that in the event a designated MCO is not providing the necessary and appropriate services, the consumer should be able to request to change MCOs.

State Response:

The proposed tentative assignment process is intended to facilitate a smooth transition between delivery systems and to provide numerous opportunities for members to make informed choices regarding MCO enrollment. As described in the published waivers, the State will begin accepting MCO selections from current Medicaid beneficiaries beginning in fall 2015. Members will receive a tentative, or preliminary, assignment that takes into consideration such factors as related family member assignment, and geographic considerations. Once receiving this tentative assignment, members will have an opportunity to choose another MCO prior to the assignment becoming effective, with the support of an independent Enrollment Broker. A member's MCO assignment for January 2016 will become effective on December 17, 2015 based on their tentative assignment if an alternative choice is not made. Members will also have ninety days to change MCOs without cause after the assignment or member choice is effective. Finally, all members may change their MCO annually and may disenroll for certain good cause reasons.

While the State will not be amending the proposed tentative assignment process, it will consider implementing several commenters' operational recommendations. Specifically, enrollment notices will be presented to members in a way that sets forth enrollment options first, and then describes the tentative assignment process. This is intended to assist members to understand their right to select the MCO that best meets their needs. Further, samples notices will be sent providers, including case managers, via the Individualized Services Information System (ISIS) and through Informational Letters to assist with disseminating information. Finally, the State will investigate the feasibility of conducting member interviews to assess the whether there is an enrollment manipulation.

j. Outreach

Comments Received:

Several comments were received related to member outreach. In general, these commenters felt the State should solicit greater stakeholder input in developing the Initiative and that members were unaware of the implications of the transition to managed care. One commenter suggested the State monitor the effectiveness of the oversight committee and public meetings, and make modifications to the Initiative as needed. Another commenter suggested that the state establish an open enrollment period.

State Response:

The State has developed a robust communication and education plan regarding the Initiative. On February 16, 2015, DHS released a preliminary Request for Proposals (RFP) for the Initiative. This release was followed by the development of a dedicated web page, various meetings with stakeholder committees and organizations, as well as a series of public meetings to solicit feedback on key program design elements and MCO contract requirements. Stakeholders have also had the opportunity to comment on the Initiative through the public notice and hearing process, during which time stakeholders were invited to review waiver documents, provide comment, and ask questions of State staff. Finally, the State has regularly issued press releases, "Frequently Asked Questions" documents, fact sheets, and presentation documents to help inform the public and to facilitate an ongoing dialogue regarding the Initiative.

While the State will not be amending the proposed waivers, it will be adopting several commenters' recommendations. Specifically, the State will continue to work with member advocacy organizations to communicate the transition to members and to ensure they understand its impact. In addition, the State will begin facilitating training sessions for providers over the coming months to ensure continuity of care and reimbursement under the Initiative. Finally, during the enrollment process, the State will review and work to update its HCBS enrollee database to facilitate effective transmission of information.

k. Implementation Timeline

Comments Received:

Several comments were received related to the implementation timeline for the Initiative. In general, these commenters felt the implementation date of January 1, 2016 may be aggressive, could jeopardize member health and safety, could cause claims processing issues, and may not allow time for MCOs to establish provider networks. Recommendations have been made to postpone implementation to at least July 1, 2016, and/or to proceed with a "phased" approach ending with HCBS Waiver enrollees.

State Response:

The State has implemented multiple strategies to assure beneficiary continuity of care will be achieved as part of the implementation and is committed to maintaining the existing timeline for implementation. To begin with, a comprehensive readiness review process will be established to ensure that all MCOs are prepared to initiate operations prior to January 1, 2016. This process will assess the MCOs' capability to provide services in accordance with their contract in areas such as, maintaining provider networks, processing service authorizations, and paying claims within contractually required timeframes. No MCO will be permitted to enroll members without meeting the State's expectations for readiness. Finally, the State has selected MCOs with demonstrated experience serving Medicaid enrollees, and that are well positioned to help the State achieve its goals under the Initiative.

l. Reimbursement

Comments Received:

Several comments were received related to MCO and provider reimbursement. With respect to MCOs, commenters suggested that the State conduct audits of payments to MCOS to ensure plan compliance and performance. One commenter suggested that the established rates were not actuarially sound and were not developed according to CMS guidelines. Concerning providers, commenters suggested that the State increase current reimbursement rates, that critical access hospitals continue to be paid on a cost-basis, that MCOs be required to make per-member/per-month payment to primary care providers, and that MCOs pay providers at a level not less than the most recent DRG base rates for inpatient services and the most recent MAPC rates for outpatient services. Two commenters also suggested the State's limitation of indirect administrative costs to 23% under 441 Iowa Administrative Code 79.1(d)(3) (i.e., methodology for determining the reasonable and proper cost for fee-for-service providers of case management) was too high. Finally, several commenters supported the State's efforts to preserve the Hospital Assessment program during implementation of managed care.

State Response:

Rates established for the Initiative meet the rate-setting criteria established by the CMS, have been certified as being actuarially sound, and will be provided to CMS for review and approval. Further, the proposed medical loss ratio requires that MCOs spend at least 88% of premium dollars on medical care (i.e., at least $0.88 of every premium dollar must be spent on medical care, while the remaining $0.12 can go toward administration and profits). This not only consistent with the majority of states implementing managed care, it also meets the standard set forth in the recently proposed CMS rule regarding Medicaid managed care (CMS-2390-P).

MCOs are required to reimburse all in-network provider types at rates that are equal to or exceed the Agency designated floor for current Iowa Medicaid fee-for-service rates. These rates are established pursuant to 441 Iowa Administrative Code 79.1. Generally, institutional providers are reimbursed on a prospective or retrospective cost-related basis, and practitioners are reimbursed according to a fee schedule. The latter are determined with advice and consultation from appropriate professional groups and are increased on an annual basis by an economic index reflecting overall inflation as well as inflation in office practice expenses of the particular provider category involved. Fee schedules in effect for the providers

covered by fee schedules can be obtained at: http://dhs.iowa.gov/ime/providers/csrp/fee-schedule. Payment levels for fee schedule providers of service may be altered upon direction of the Iowa Legislature through Medicaid appropriations. All provider rates are part of Iowa Administrative Code and are subject to public notice and comment any time there is change.

Finally, MCOs must establish performance-based incentive systems for their contracted providers, subject to State approval prior to implementation and before making any changes to an approved incentive. Incentive programs will be structured to encourage positive member engagement and health outcomes that are tailored to health issues prevalent among enrolled membership. The MCOs must provide information concerning its physician incentive plan, upon request, to its members and in any marketing materials in accordance with the disclosure requirements stipulated in federal regulations.

m. Quality/Safety

Comments Received:

Several comments were received related to the quality of services provided to beneficiaries following the transition to managed care. Generally, commenters felt that the current delivery system was capable of providing higher quality services to beneficiaries.

State Response:

No changes were made to the waivers as a result of these comments, as the Initiative is designed to build upon the success and philosophy of the current State program to enhance the delivery of coordinated care services and improve the health outcomes for all beneficiaries. A number of quality improvement mechanisms are established to accomplish this goal. MCOs are contractually obligated to, and will be held accountable for, improving quality outcomes and developing Quality Management/Quality Improvement (QM/QI) programs with objectives that are measurable, realistic and supported by consensus among the MCO's medical and quality improvement staff. Through the QM/QI program, MCOs must have ongoing comprehensive quality assessment and performance improvement activities aimed at improving the delivery of healthcare services to its members. Quality information must be made available to members based on their preferred method of communication. As a key component of its QM/QI program, MCOs must develop incentive programs for both providers and members, with the ultimate goal of improving health outcomes. All QM/QI programs are subject to state approval. Further, all MCOs will be assessed according to standards established by the State and are required to provide all information and reporting necessary to complete this assessment. In accordance with federal law, the State will regularly monitor and evaluate MCO compliance with the standards established by the State and the MCOs QM/QI program. Finally, MCOs will be required to attain and maintain accreditation through the National Committee for Quality Assurance (NCQA) or the Utilization Review Accreditation Commission (URAC). In the event an MCO fails to attain and maintain accreditation in the required timeframe, the MCO must submit a formal corrective action plan for State review and approval.

Separate for the above considerations, Iowa was one of eleven states awarded a State Innovation Model (SIM) grant to test whether quality and value oriented healthcare reforms could produce superior results when implemented in the context of a state-sponsored Plan. The $43 million grant was announced in December of 2014, and was incorporated into Iowa's managed care approach via specific requirements for Value Based Purchasing (VBP) and a common quality measurement tool, called the Value Index Score (VIS) that is used across delivery systems. Because the VIS measures quality at a population health level, it ensures MCO savings is linked to whole-system improvement supporting all members, not just managing isolated pockets of opportunity within the Medicaid population. This initiative is a multi-payor strategy that aligns Medicaid with Wellmark Blue Cross and Blue Shield (specifically) and Medicare (more generally) bringing the scale necessary to influence real delivery system reform across the state.

Finally, the Initiative has been designed to provide high quality health care and create a level of accountability that does not exist today. The State will conduct ongoing reviews of MCO accreditation requirements to ensure standards are maintained. Further, the State monitor MCOs on a variety of key metrics on an on-going basis (e.g., provider network and access standards).

n. MCO Standardization

Comments Received:

Several comments were received related to the standardization of processes across MCOs and concern that variations may be cumbersome for providers. For example, recommended areas of alignment included: (1) primary care provider

assignment and algorithms; (2) quality and performance measures; (3) approach to processing, analyzing, and sharing claims and other data with providers; (3) consistent approaches to value based contracting with providers; (4) provider credentialing and application processes; (5) prior authorizations/approvals forms and processes; (6) prescription management; (7) program requirements for chronic conditions and integrated health homes; (8) utilization management processes; (9) health risk assessment tools; and (10) processes to identify 340B claims.

State Response:

The commercial market does have variation across health plans for different operational processes so some variation is to be expected. The MCOs are required to provide training to providers on key procedures and the State will monitor key processes after the Initiative is implemented and consider adjustments if necessary. The state will also collaborate with the MCOs to ensure that processes are developed as consistently and efficiently across MCOs as possible. In addition, common approaches may be leveraged to support overarching goals, such as the required use of VIS across all MCO's as a standard to measure delivery system quality within value based purchasing.

o. Tribal Consultation

Only one question was received asking whether I/T/U providers would be required to enroll with an MCO in order to receive reimbursement for services rendered to American Indian/Alaska Natives (AI/AN) who opt to enroll in managed care through the Initiative. The State informed this provider that he/she, whether participating in the network or not, will be paid for covered Medicaid or CHIP managed care services provided to AI/AN enrollees who are eligible to receive services either: (1) at a rate negotiated between the managed care entity and the provider; or (2) if there is no negotiated rate, at a rate not less than the level and amount of payment that would be made if the provider were not an I/T/U provider. Further, the State will operate in compliance with the provisions of the American Recovery and Reinvestment Act and CMS guidance. As a result, no changes were made to the waiver as a result of this comment.